Adopted	Rejected

COMMITTEE REPORT

YES:	9
NO:	4

MR. SPEAKER:

Your Committee on ***Insurance, Corporations and Small Business*** *, to which was referred Senate Bill 462 , has had the same under consideration and begs leave to report the same back to the House with the recommendation that said bill* ***be amended*** *as follows:*

Page 12, line 28, reset in roman "one".

Page 12, line 28, delete "two".

Page 12, line 29, reset in roman "fifty".

Page 12, line 29, reset in roman "(150%)".

Page 12, line 29, delete "(200%)".

Page 14, between lines 19 and 20, begin a new paragraph and insert:

"SECTION 5. IC 27-8-10-2.2 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003]: **Sec. 2.2. If, after the close of a fiscal year:**

(1) the association determines that there is a net loss for the fiscal year;

(2) the net loss for the fiscal year is assessed by the association to all members; and

(3) the financial capability of the association to meet the incurred or estimated claims expenses or operating expenses

of the association becomes uncertain due to the failure or refusal of members of the association to meet their financial obligations as members of the association or due to any other reason;

this chapter is void and IC 27-8-10.1 becomes effective.".

Page 14, line 33, after "(1)" insert "**approve and**".

Page 15, between lines 9 and 10, begin a new paragraph and insert:

"**(b) A program approved and implemented under this section may not require prior authorization for a prescription drug prescribed for the treatment of:**

(1) human immunodeficiency virus (HIV) or acquired immune deficiency syndrome (AIDS) and included on the AIDS drug assistance program formulary adopted by the state department of health under the federal Ryan White CARE Act (42 U.S.C. 300ff); or

(2) hemophilia according to recommendations of the:

(A) Advisory Committee on Blood Safety and Availability of the United States Department of Health and Human Services; or

(B) Medical and Scientific Advisory Council of the National Hemophilia Foundation.".

Page 15, line 10, delete "(b)" and insert "**(c)**".

Page 15, delete lines 12 through 16, begin a new paragraph and insert:

"**(d) A disease management program for which federal funding is available is considered to be approved by the association under this section.**

(e) An insured who has a chronic disease for which at least one (1) chronic disease management program is approved under this section shall participate in an approved chronic disease management program for the chronic disease as a condition of coverage of treatment for the chronic disease under an association policy.".

Page 15, line 19, after "approve" delete ":".

Page 15, line 20, delete "(1)".

Page 15, run in lines 19 through 20.

Page 15, line 21, delete "; or".

Page 15, delete lines 22 through 23.

Page 15, run in lines 21 and 24.

Page 15, line 25, delete "for treatment of a chronic disease." and insert "**.**".

Page 15, line 27, delete "for treatment of a chronic disease".

Page 15, line 27, after "covered" insert "**if the prescription drug is obtained from**".

Page 15, delete lines 28 through 35, begin a new line block indented and insert:

"**(1) a pharmacy approved under subsection (a); or**

(2) a pharmacy that:

(A) is not approved under subsection (a); and

(B) agrees to sell the prescription drug at the same price as a pharmacy approved under subsection (a).

(c) A prescription drug that is:

(1) covered under an association policy; and

(2) obtained from a pharmacy not described in subsection (b); is covered for an amount equal to the price at which a pharmacy described in subsection (b) will sell the prescription drug, with the remainder of the charge for the prescription drug to be paid by the insured.".

Page 16, line 25, after "(a)" insert "**A person is not eligible for an association policy if the person is eligible for Medicaid. A person other than a federally eligible individual may not apply for an association policy unless the person has applied for Medicaid not more than sixty (60) days before applying for the association policy.**

(b)".

Page 16, line 25, strike "subsections (b) and" and insert "**subsection**".

Page 16, line 32, strike "(b)" and insert "**(c)**".

Page 16, line 32, delete "," and insert "**and subsection (a),**".

Page 17, line 14, delete "(c)" and insert "**(d)**".

Page 17, line 15, after "On the" insert "**first**".

Page 17, line 15, after "date" insert "**on which**".

Page 17, line 16, after "date" insert "**on which**".

Page 17, line 21, after "On the" insert "**first**".

Page 17, line 21, after "date" insert "**on which**".

Page 17, line 23, strike "(d)" and insert "**(e)**".

Page 17, line 39, strike "(e)" and insert "**(f)**".

Page 18, line 10, strike "(f)" and insert "**(g)**".

Page 18, line 10, strike "(g)," and insert "**(h),**".

Page 18, line 12, reset in roman "three (3)".

Page 18, line 12, delete "six (6)".

Page 18, line 15, reset in roman "three (3)".

Page 18, line 15, delete "six (6)".

Page 18, line 18, strike "(g)" and insert "**(h)**".

Page 18, line 21, strike "(b)," and insert "**(c),**".

Page 18, line 29, strike "(h)" and insert "**(i)**".

Page 18, line 36, delete "that" and insert "**on which**".

Page 19, between lines 21 and 22, begin a new paragraph and insert:

SECTION 13. IC 27-8-10.1 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003]:

Chapter 10.1. Guaranteed Individual Health Benefit Plan Coverage

Sec. 1. This chapter becomes effective on the date that the Indiana comprehensive health insurance association established under IC 27-8-10-2.1 makes the determination described in IC 27-8-10-2.2 and IC 27-8-10 becomes void.

Sec. 2. As used in this chapter, "accident and sickness insurer" means an insurer that provides coverage for basic health care services under a policy of accident and sickness insurance.

Sec. 3. As used in this chapter, "actively market" means to offer a health benefit plan to an individual who does not currently receive benefits under the health benefit plan.

Sec. 4. As used in this chapter, "basic health benefit plan" means a health benefit plan that meets the following requirements:

(1) After a deductible, provides coverage for at least eighty percent (80%) of the cost of medically necessary basic health care services.

(2) Meets the requirements for an individual:

(A) policy of accident and sickness insurance specified in IC 27-8-5; or

(B) contract with a health maintenance organization specified in IC 27-13.

Sec. 5. As used in this chapter, "basic health care services"

means the following services:

(1) If health benefit plan coverage is provided under a contract with a health maintenance organization, preventive care.

(2) Inpatient and outpatient hospital and physician care.

(3) Diagnostic laboratory care.

(4) Diagnostic and therapeutic radiological services.

(5) Emergency care.

Sec. 6. As used in this chapter, "church plan" has the meaning set forth in the federal Employee Retirement Income Security Act of 1974 (26 U.S.C. 414(e)).

Sec. 7. As used in this chapter, "creditable coverage" has the meaning set forth in the federal Health Insurance Portability and Accountability Act of 1996 (26 U.S.C. 9801(c)(1)).

Sec. 8. As used in this chapter, "federally eligible individual" means an individual:

(1) for whom, as of the date on which the individual seeks coverage under this chapter, the total period of creditable coverage is at least eighteen (18) months and whose most recent prior creditable coverage was under a:

(A) group health plan;

(B) governmental plan; or

(C) church plan;

or health insurance coverage in connection with any of those plans;

(2) who is not eligible for coverage under:

(A) a group health plan;

(B) Part A or Part B of Title XVIII of the federal Social Security Act; or

(C) a state plan under Title XIX of the federal Social Security Act (or any successor program);

and does not have other health insurance coverage;

(3) with respect to whom the individual's most recent coverage was not terminated for factors relating to nonpayment of premiums or fraud;

(4) who, if after being offered the option of continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) (29 U.S.C. 1191b(d)(1)),

or under a similar state program, elected such coverage; and

(5) who, if after electing continuation coverage described in subdivision (4), has exhausted continuation coverage under the provision or program.

Sec. 9. As used in this chapter, "governmental plan" means a plan as defined under the federal Employee Retirement Income Security Act of 1974 (26 U.S.C. 414(d)) and any plan established or maintained for its employees by the United States government or by any agency or instrumentality of the United States government.

Sec. 10. As used in this chapter, "health benefit plan" means coverage of basic health care services under a:

(1) policy of accident and sickness insurance; or

(2) contract with a health maintenance organization.

Sec. 11. As used in this chapter, "health benefit plan provider" means:

(1) an accident and sickness insurer; or

(2) a health maintenance organization;

that provides coverage under a health benefit plan.

Sec. 12. As used in this chapter, "health maintenance organization" has the meaning set forth in IC 27-13-1-19.

Sec. 13. As used in this chapter, "individual contract" has the meaning set forth in IC 27-13-1-21.

Sec. 14. As used in this chapter, "individual health benefit plan" means a health benefit plan that is:

(1) issued on an individual basis; or

(2) entered into as an individual contract;

and may include coverage of dependents of the individual.

Sec. 15. As used in this chapter, "policy of accident and sickness insurance" has the meaning set forth in IC 27-8-5-1(a).

Sec. 16. As used in this chapter, "qualified individual" means an individual who meets one (1) of the following criteria:

(1) At the effective date of coverage, the individual is not eligible for coverage:

(A) under a group health benefit plan that provides coverage for basic health care services;

(B) under Part A or Part B of Title XVIII of the federal Social Security Act;

(C) under a state plan under Title XIX of the federal Social

Security Act (or any successor program); or

(D) available through an employer plan that provides coverage for basic health care services.

(2) The individual is a federally eligible individual.

For purposes of this section, an individual may be a qualified individual if the individual is eligible for Medicare coverage and is less than sixty-five (65) years of age.

Sec. 17. As used in this chapter, "standard health benefit plan" means a health benefit plan that meets the following requirements:

(1) After a deductible, provides coverage for at least eighty percent (80%) of the cost of the following medically necessary services:

(A) Basic health care services.

(B) Mental health services.

(C) Services for alcohol and drug abuse.

(D) Dental services.

(E) Vision services.

(F) Long term rehabilitation treatment.

(2) Meets the requirements for an individual:

(A) policy of accident and sickness insurance specified in IC 27-8-5; or

(B) contract with a health maintenance organization specified in IC 27-13.

Sec. 18. (a) A health benefit plan provider that provides coverage in Indiana under at least one (1) individual health benefit plan shall actively offer to provide coverage to a qualified individual under all health benefit plans the health benefit plan provider actively markets to individuals in Indiana, including at least:

(1) one (1) basic health benefit plan; and

(2) one (1) standard health benefit plan.

(b) A health benefit plan provider shall provide coverage to a qualified individual under the health benefit plan for which the qualified individual applies.

Sec. 19. A health benefit plan provider may not impose a preexisting condition limitation or exclusion on individual health benefit plan coverage provided under section 18 of this chapter.

Sec. 20. (a) Premiums for individual basic health benefit plan

coverage provided under section 18 of this chapter may not exceed one hundred fifty percent (150%) of the average premium charged by health benefit plan providers for basic health benefit plan coverage in Indiana during the previous calendar year, as determined by the department under section 21(a) of this chapter.

(b) Premiums for individual standard health benefit plan coverage provided under section 18 of this chapter may not exceed one hundred fifty percent (150%) of the average premium charged by health benefit plan providers for standard health benefit plan coverage in Indiana during the previous calendar year, as determined by the department under section 21(b) of this chapter.

Sec. 21. (a) The department shall calculate and make available to health benefit plan providers the average premium charged for basic health benefit plan coverage as reported to the department under IC 27-1-22 by the five (5) health benefit plan providers with the largest premium volume in Indiana during the previous calendar year.

(b) The department shall calculate and make available to health benefit plan providers the average premium charged for standard health benefit plan coverage as reported to the department under IC 27-1-22 by the five (5) health benefit plan providers with the largest premium volume in Indiana during the previous calendar year.

Sec. 22. Coverage for basic health care services provided under this chapter shall be provided in compliance with the federal Health Insurance Portability and Accountability Act of 1996 (P.L.104-191).

SECTION 14. [EFFECTIVE JULY 1, 2003] **Upon the effective date of IC 27-8-10.1, as added by this act, the legislative services agency shall prepare legislation for introduction during the next succeeding regular session of the general assembly to organize and correct statutes affected by IC 27-8-10.1, as added by this act.**".

Page 19, line 23, delete "IC 27-8-10-4 and" and insert "**IC**

27-8-10-4,".

Page 19, line 24, delete "both" and insert "**and IC 27-8-10-6, all**".

Renumber all SECTIONS consecutively.

(Reference is to SB 462 as reprinted February 26, 2003.)

and when so amended that said bill do pass.

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Representative Fry